

Date of last visit to a physician: \_\_\_\_\_  
 Doctor's name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Name of current personal Physician: \_\_\_\_\_

Purpose of Visit: \_\_\_\_\_  
 Phone #: ( ) \_\_\_\_\_

Family History	Name:	Age:	If Deceased, Cause of Death	Age at Death	Has any blood relative ever had:	Encircle No or Yes	Who?
Father					Alcoholism	No Yes	
Mother					Drug Problems	No Yes	
Brother/s	1.				Depression	No Yes	
Or	2.				Mental Problems	No Yes	
Sister/s	3.				Psychiatric Treatment	No Yes	
	4.				Epilepsy	No Yes	
Spouse	5.				Neurological Disorder	No Yes	
Children	1.				Suicidal Attempts	No Yes	
	2.						
	3.						
	4.						
	5.						
Medical History	Please place a check ✓ in front of any questions you would like to discuss in more detail with the Doctor.						

Have you ever had:	Circle	
	No	Yes
Rheumatic Fever	No	Yes
Epilepsy	No	Yes
Tuberculosis	No	Yes
Nervousness	No	Yes
Mental Problem	No	Yes
Arthritis	No	Yes
Bone or Joint Disease	No	Yes
Meningitis	No	Yes
Gonorrhea or Syphilis	No	Yes
Jaundice	No	Yes
Thyroid Disease	No	Yes
Diabetes	No	Yes
Cancer	No	Yes
High Blood Pressure	No	Yes
Heart Disease	No	Yes
Asthma	No	Yes
Stroke	No	Yes

When was your last physical Examination? \_\_\_\_\_  
 What Medications are you allergic to? \_\_\_\_\_  
 Have you ever been hospitalized for any major illness? Specify: \_\_\_\_\_  
 \_\_\_\_\_  
 When and where you hospitalized: \_\_\_\_\_  
 Have you ever had an operation? Type and When: \_\_\_\_\_  
 Do you currently have any dental problems? \_\_\_\_\_  
 Have you had any complications from a childhood disease? \_\_\_\_\_  
 When was your last chest x-ray? \_\_\_\_\_  
 When was your last electrocardiogram? \_\_\_\_\_  
 What do you weigh now? \_\_\_\_\_  
 What was your weight one year ago? \_\_\_\_\_  
 What was your maximum weight and date? \_\_\_\_\_  
 Has Sleep been a problem? \_\_\_\_\_  
 Has sex been a problem? \_\_\_\_\_  
 Has there been a change in appetite? \_\_\_\_\_  
 What activities do you do for fun? \_\_\_\_\_  
 What time do you feel your best? \_\_\_\_\_  
 What physical complaints, if any do you have? \_\_\_\_\_

What medications do you take on a regular basis? \_\_\_\_\_

Doctor's Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

County of San Diego  
 Health and Human Services Agency  
 Mental Health Services

# MEDICAL HISTORY QUESTIONNAIRE

Client: \_\_\_\_\_

MR/Client ID #: \_\_\_\_\_

Program: \_\_\_\_\_

Circle No Yes

Night sweats	No	Yes
Shortness of breath	No	Yes
Palpitations or fluttering heart	No	Yes
Swelling of hands, feet or ankles	No	Yes
Back, arm or leg problem	No	Yes
Varicose veins	No	Yes
Kidney disease or stones	No	Yes
Bladder disease	No	Yes
Albumin, sugar, pus, blood in urine	No	Yes
Difficulty in urinating	No	Yes
Abnormal thirst	No	Yes
Stomach trouble or ulcer	No	Yes
Indigestion	No	Yes
Appendicitis	No	Yes
Liver or gallbladder disease	No	Yes
Colitis or other bowel disease	No	Yes
Hemorrhoids or rectal bleeding	No	Yes
Constipation or diarrhea	No	Yes
Crying spells	No	Yes
Suicidal thoughts	No	Yes
Loss of appetite	No	Yes

Do you smoke: ☐ Tobacco ☐ Cigarettes How many packs a day \_\_\_\_\_

Do you drink: ☐ Coffee ☐ Tea ☐ Cola Drinks How many cups/glasses a day \_\_\_\_\_

Do you take alcoholic beverages: ☐ Never ☐ Rarely ☐ Moderately ☐ Daily

Has alcohol use been a problem: ☐ Yes ☐ No Have you ever been treated for alcoholism: ☐ Yes ☐ No

Have you ever taken street drugs: ☐ Yes ☐ No Which drug/s: \_\_\_\_\_

During what Period: \_\_\_\_\_ How often: \_\_\_\_\_

When was the last time that you used any drug: \_\_\_\_\_

Have you ever been treated for a drug problem: ☐ Yes ☐ No When: \_\_\_\_\_

Age at onset: \_\_\_\_\_ Cycle: \_\_\_\_\_ Days (from start to start) Date of last period: \_\_\_\_\_  
Duration: \_\_\_\_\_ Days Regular: ☐ Yes ☐ No Pain or Cramps: ☐ Yes ☐ No  
How many pregnancies: \_\_\_\_\_ Miscarriages: \_\_\_\_\_ Age of youngest living child: \_\_\_\_\_

Branch \_\_\_\_\_ Rank at Discharge \_\_\_\_\_  
 When did you serve? \_\_\_\_\_ to \_\_\_\_\_  
 Type of discharge \_\_\_\_\_

Date form Completed:\_\_\_\_\_

Physician's Signature &amp; Date Reviewed.

County of San Diego  
Health and Human Services Agency  
Mental Health Services

**MEDICAL HISTORY QUESTIONNAIRE**

HHSA:MHS-911 (12/1/2001)

**Client:** \_\_\_\_\_

**MR/Client ID #:** \_\_\_\_\_

**Program:** \_\_\_\_\_